U. S. No. 2
Rev.—11-10-39
Rev. 5-17-39
Form I X21492

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10919

Registration District No. 310 — Primary Registration District No. 5429A 4186 — Registrar's No. 149

1. PLACE OF DEATH:

(a) County Gentry

(b) City or town Darlington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)
In this community 10 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gentry

(c) City or town Darlington
(If outside city or town limits, write "RURAL")

(d) Street No. 2
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Sarah Elizabeth Hill

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife W. R. Hill

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Dec. 18, 1846 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
93	2	22	____ hr. ____ min.

9. Birthplace Henry Co. (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ____

FATHER
12. Name James H. Miles
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Emeline Crooper
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant W. H. Hill
(b) Address Darlington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 12, 1940 (Month) (Day) (Year)
(c) Place: burial or cremation Rouse Cemetery

18. (a) Signature of funeral director Clifford Brake
(b) Address Albany, Mo.

19. (a) March 13 (Date received local registrar) (b) Mattie Beard (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11th year 1940 hour 1 minute A M.

21. I hereby certify that I attended the deceased from March 1st, 1940, to March 11, 1940, that I last saw her alive on March 10th, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Bronchopneumonia	2 days
Due to: Acute Influenza	6 or 7 days
Due to:	
Other conditions (Include pregnancy within 3 months of death): N/N	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 2 97 (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature W. R. Campbell (M. D. or other) 1
Address Albany Mo Date signed March 11th 1940

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number 446-42
Date File APR-3 REC'D

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Me

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Robert Brooks

Licensed Embalmer No. 3329

P. O. Address Albany, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.